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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2009-140
SHERRYL KAY VANDERSCHNIT KENT 135 Tapia Drive San Francisco, CA 94132	OAH No.
Registered Nurse License No. 258901	**A C C U S A T I O N**
Respondent.	

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H, R.N (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 1975, the Board of Registered Nursing issued Registered Nurse License Number 258901 to Sherryl Kay Vanderschnit Kent (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

STATUTORY AND REGULATORY PROVISIONS

4. Section **2750** of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section **2764** of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section **2761** of the Code states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

. . .

7. Section **2762** of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible

entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. California Code of Regulations, title 16, section **1442**, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

9. California Code of Regulations, title 16, section **1443**, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

10. Section **125.3** of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DANGEROUS DRUGS/CONTROLLED SUBSTANCES

11. Section **4021** of the Code states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

12. Section **4022** of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use, except veterinary drugs that are labeled as such, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this

device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

13. **Hydrocodone** is the generic name for **Vicodin**, a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(j) and a dangerous drug per Business and Professions Code section 4022. Hydrocodone is a narcotic analgesic that is used to treat pain.

14. **Morphine** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug per Business and Professions Code section 4022.

15. **Toradol** is a brand name for Ketoprofen, a dangerous drug within the meaning of Code section 4022.

FACTUAL SUMMARY

16. In October, 2005, Respondent was working as a registered nurse at California Pacific Medical Center (hereinafter "CPMC"), a hospital located in San Francisco, California.

17. While on duty, Respondent removed various medications from the Pyxis[1] machine but failed to account for disposition of the medications. Respondent also documented administration of doses that were lower than the doses prescribed by the patients' treating physicians. The circumstances are as follows:

Patient F[2]

18. On October 5, 2005, at 18:12 hours, Patient F's physician ordered

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1. Pyxis is a drug-dispensing machine that documents the withdrawal of medications by nurses in the hospital. In order to obtain medications from the Pyxis, a nurse must enter into the machine his or her log-on name and password.

2. Patient information is withheld to protect patient privacy.

(LORTAB, VICODIN) ACETAMINOPHEN 500 MG/HYDROCODONE 5 MG TAB, #1-2, PO, Q3 TO Q4H, PRN PAIN (PAIN SCALE: 1-4 GIVE 1TAB, 5-10 GIVE 2TABS).

19. On October 7, 2005, at 16:29 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient F, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent documented on Patient F's flow sheet that Patient F's pain scale at the time of administration of the medication was "5."

20. On October 7, 2005, at 20:51 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient F, on Patient F's flow sheet, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent also failed to make any entry regarding the administration of medication at this time in Patient F's electronic Medication Administration Record. Respondent documented on Patient F's flow sheet that Patient F's pain scale at the time of administration of the medication was "6."

Patient G

21. On October 7, 2005, at 15:18 hours, Patient G's physician ordered (LORTAB, VICODIN) ACETAMINOPHEN 500 MG/ HYDROCODONE 5MG TAB, #1-2, PO, Q3 TO Q4H, PRN PAIN (PAIN SCALE: 1-4 GIVE 1TAB, 5-10 GIVE 2TABS).

22. On October 8, 2005, at 17:01 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets but failed to chart administration of the tablets or otherwise account for their disposition. Respondent noted "Denies" in the "Pain Scale" section of Patient G's chart at 16:00 hours.

23. On October 7, 2005, at 14:41 hours, Patient G's physician ordered MORPHINE SULFATE INJ 3 MG, IV PUSH, Q1H, PRN PAIN.

24. On October 7, 2005, at 21:20 hours, Respondent removed from the Pyxis one syringe of Morphine, 4 mg, and documented administration of 3 mg Morphine to patient G, but failed to chart administration of the remaining one mg of Morphine or otherwise account for its disposition.

Patient H

25. On October 8, 2005, at 12:53 hours, Patient H's physician ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #1, PO, Q3-4H PRN PAIN (PAIN SCALE 1-4), and also ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #2, PO, Q3-4H PRN PAIN (PAIN SCALE 5-10).

26. On October 8, 2005, at 17:02 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient H, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent documented on Patient H's flow sheet that Patient H's pain scale at the time of administration of the medication was "6."

27. On October 8, 2005, at 23:12 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient H, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent documented on Patient H's flow sheet that Patient H's pain scale at the time of administration of the medication was "6."

28. On October 9, 2005, at 16:42 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient H, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent documented on Patient H's flow sheet that Patient H's pain scale at the time of administration of the medication was "7."

29. On October 9, 2005, at 22:43 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets but failed to chart administration of the tablets or otherwise account for their disposition.

Patient J

30. On October 8, 2005, at 17:32 hours, Patient J's physician ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #1, PO, Q3-4H PRN PAIN (PAIN SCALE 1-4), and also ordered (LORTAB, VICODIN)

ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #2, PO, Q3-4H PRN PAIN (PAIN SCALE 5-10).

31. On October 9, 2005, at 19:54 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets but failed to chart administration of the tablets or otherwise account for their disposition.

Patient O

32. On October 14, 2005, at 11:07 hours, Patient O's physician ordered (TORADOL) KETOROLAC INJ 30MG, IV, Q6H, PRN PAIN, X1DAY –FOR PAIN NOT RELIEVED BY OTHER MEDS.

33. On October 14, 2005, at 22:00 hours, Respondent removed from the Pyxis four Ketorolac 30 mg/1ml injectables and documented administration of one 30 mg/ml injectable to patient O, but failed to chart administration of the remaining three injectables or otherwise account for their disposition. When Respondent's shift was completed and the night nurse took over, Patient O reported that she had not received an injection of Ketorolac at 22:00 hours, and in fact had last been administered such medication at 16:00 hours.

Patient P

34. On October 17, 2005, at 17:17 hours, Patient P's physician ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #1, PO, Q3-4H PRN PAIN -- FOR PAIN SCALE 1-4, and also ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #2, PO, Q3-4H PRN PAIN – FOR PAIN SCALE 5-10.

35. On October 17, 2005, at 21:22 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient P, on Patient P's flow sheet, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent also failed to make any entry regarding the administration of medication at this time in Patient P's electronic Medication Administration Record. Respondent documented on Patient P's flow sheet that Patient P's pain scale at the time of administration of the medication was "6."

Patient R

36. On October 16, 2005, at 03:52 hours, Patient R's physician ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #1, PO, Q3-4H PRN PAIN (PAIN SCALE 1-4), and also ordered (LORTAB, VICODIN) ACETAMINOPHEN 500MG/HYDROCODONE 5MG TAB, #2, PO, Q3-4H PRN PAIN (PAIN SCALE 5-10).

37. On October 17, 2005, at 21:35 hours, Respondent removed from the Pyxis two Hydrocodone/APAP 5/500 tablets and documented administration of one tablet to patient R, but failed to chart administration of the remaining tablet or otherwise account for its disposition. Respondent documented on Patient R's flow sheet that Patient R's pain scale at the time of administration of the medication was "6."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

38. Respondent is subject to disciplinary action under section 2761(a) in that she acted unprofessionally, as set forth above in paragraphs 16 through 37.

SECOND CAUSE FOR DISCIPLINE

(Grossly Inconsistent Record Entries)

39. Respondent is subject to disciplinary action under sections 2761 and 2762(e) of the Code in that she made grossly incorrect, grossly inconsistent, or unintelligible entries in a hospital record pertaining to controlled substances, as set forth above in paragraphs 16 through 37.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

40. Respondent is subject to disciplinary action under section 2761(a)(1) of the Code in that she acted with incompetence and/or gross negligence in carrying out usual certified or licensed nursing functions, as set forth above in paragraphs 16 through 37.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 258901, issued to Sherryl Lay Vanderschnit Kent;

2. Ordering Sherryl Lay Vanderschnit Kent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/10/08

RUTH ANN TERRY, M.P.H, R.N
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant